EngenderHealth
for a better life

Agir Pour La Planification Familiale – AgirPF

Performance Monitoring Plan (PMP)
July 5, 2013 – July 4, 2018
Agreement No. AID-624-A-13-00004

EngenderHealth, Inc.

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Acronyms and Abbreviations

3Is	Inform, Inspire, and Involve Approach
BPs	Best Practices
CHW	Community Health Worker
COPE®	Client-Oriented, Provider-Efficient
CPR	Contraceptive Prevalence Rate
CPT	Contraceptive Procurement Table
CYP	Couple-Years of Protection
DHS	Demographic and Health Survey
DQA	Data Quality Assessment
FI	Futures Institute
FP	Family planning
IP	Implementing Partner
IRB	Institutional Review Board
KAP	Knowledge, Attitudes, and Practice
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOU	Memorandum of Understanding
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization
OR	Operations Research
PMP	Performance Monitoring Plan
PRISM	Performance of Routine Information System Management
RH	Reproductive Health
SBCC	Social and Behavior Change Communication
SNIS	Système National d'Information Sanitaire (national health information system)
USAID	U.S. Agency for International Development
WAAF	West African Ambassadors' Fund
WHO	World Health Organization
WRA	Women of Reproductive Age

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1. Introduction

The last five decades have seen a revolution in the availability and use of family planning (FP) worldwide. FP saves lives, and it is critical to social and economic development. However, contraceptive use remains low, and unmet need is high in much of West Africa. According to the most recent Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) data, the modern contraceptive prevalence rate (CPR) is only 14–34% in urban areas of Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo, while unmet need ranges from 21 to 35%.

On July 5, 2013, the USAID/West Africa Regional Health Office awarded a five-year, $29 million cooperative agreement – the Agir Pour la Planification Familiale (AgirPF) Project – to EngenderHealth and two core partners, Futures Institute and EXP Agency Ltd. The goal of AgirPF is to enable WRA (15–49) to make, and voluntarily act on, informed decisions about FP, saving women's lives in select urban and peri-urban areas of five francophone West African countries: Burkina Faso, Cote d'Ivoire (starting in Year 3), Mauritania, Niger, and Togo. The project will work closely with Ministries of Health (MOHs) and other local partners to support the national action plans for strengthening FP that followed the February 2011 Francophone West Africa Regional Conference on Population, Development, and Family Planning held in Ouagadougou, Burkina Faso.

In the five participating countries, AgirPF will focus on the 10 largest cities (80,000+ population), with the exception of Zinder, Niger, which was not selected due to safety concerns. The focus cities are as follows:

- Burkina Faso: Ouagadougou, Bobo-Dioulasso, and Koudougou
- Côte d'Ivoire: Abidjan (starting in Year 3)
- Mauritania: Nouakchott
- Niger: Niamey, Maradi
- Togo: Lomé, Sokodé, and Kara

2. Project Results Framework

The results framework illustrates in a diagram the direct causal relationships between the incremental results of key project activities and the overall objective and goal of the intervention. The results framework of AgirPF project is presented in Figure 1.

The overall **goal** of AgirPF is to enable WRA (15–49) to make, and voluntarily act on, informed decisions about FP, thus saving women's lives.

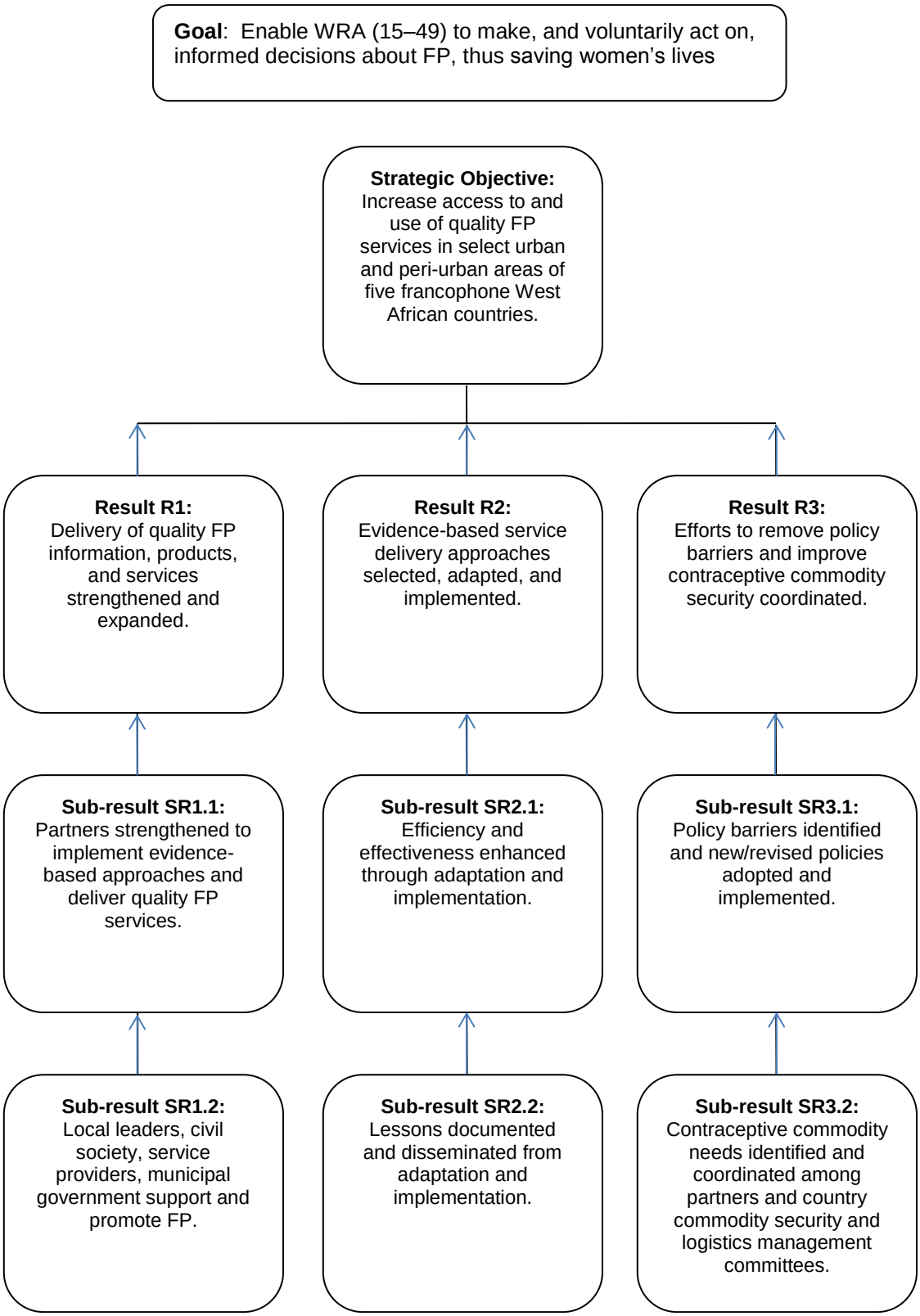
The **strategic objective** consists in increasing access to and use of quality FP services in select urban and peri-urban areas of five francophone West African countries.

The three discrete results that are necessary to achieve this strategic objective are:

- **Result R1:** Delivery of quality FP information, products, and services strengthened and expanded
- **Result R2:** Evidence-based service delivery approaches selected, adapted, and implemented
- **Result R3:** Efforts to remove policy barriers and improve contraceptive commodity security coordinated

Under each of these three results there are two sub-results.

Figure 1. AgirPF Results Framework



3. Summary of Key Activities

A detailed description of key project activities can be found in AgirPF Year One work plan. These activities are summarized by results below to provide context for the indicators that follow:

Result R1: Delivery of quality FP information, products, and services strengthened and expanded	
Sub-results	**Key Activities**
SR1.1: Partners strengthened to implement evidence-based approaches and deliver quality FP services	• Conduct baseline assessments • Identify and implement quick wins • Improve curricula for FP services • Build training systems around Centers of Excellence • Support special and mobile FP services • Organize industry-based activities, including health fairs • Support/supervise community health workers (CHWs) and prepare for handover to national health authorities (Togo only)
SR1.2: Local leaders, civil society, service providers, municipal government support and promote FP	• Conduct formative/market research • Develop/adapt SBCC strategies and messages • Implement SBCC strategies and messages • Develop 3Is package and conduct workshops to create gender-sensitive FP champions • Conduct facility walk-throughs to engage the community in identifying and addressing barriers to service use
Result R2: Evidence-based service delivery approaches selected, adapted, and implemented	
Sub-results	**Key Activities**
SR2.1: Efficiency and effectiveness enhanced through adaptation and implementation	• Select best practices (BPs) to be introduced; adapt approaches to local context • Secure necessary approvals, including MOUs and IRB approvals • Test BPs
SR2.2: Lessons documented and disseminated from adaptation and implementation	• Hold start-up workshops for project and partner staff on learning, documentation, and advocacy (LDA) strategies; develop LDA objectives • Convene the first meeting of a small core group of stakeholders to launch the process of establishing a Community of Practice for FP in West Africa • Host regional meetings and webinars for ECOWAS countries and others to disseminate selected Best Practices • Provide materials to be uploaded to website

	platforms, such as WAHO • Participate/present at regional /international meetings and conferences, • Seek opportunities for publication in journals, regional/international FP newsletters, etc.
Result R3: Efforts to remove policy barriers and improve contraceptive commodity security coordinated	
Sub-results	**Key Activities**
SR3.1: Policy barriers identified and new/revised policies adopted and implemented	• Develop a strategic action plan to address policy barriers • Prepare RAPID presentations • Build the capacity of a coalition of advocates that effectively and expediently implement AgirPF advocacy strategies • Launch initial advocacy activities including outreach to stakeholders
SR3.2: Contraceptive commodity needs identified and coordinated among partners and country commodity security and logistics management	• Introduce Reality √ in annual CPT exercises • Support DELIVER trainings on monitoring and reporting on stock levels • Establish/support FP committees or Technical Working Groups on contraceptive commodities • Introduce COPE for Contraceptive Security in Burkina Faso and Togo • Introduce mHealth technology to continuously report on stocks, link with DELIVER, advance logistics systems in each country

4. Critical Assumptions

The degree to which these results can be achieved depends on a number of assumptions that will need to be supported to achieve the project results. These assumptions are:

1. Social, political and legal environments will remain favorable to AgirPF's interventions implementation;
2. Governments will not implement new policies, standards and protocols that restrict FP services;
3. Commitment and cooperation from the Ministries of Health and partners to implement the proposed strategy is sustained throughout the life of the project and beyond;
4. There will be adequate equipment, expendable supplies and contraceptive products in the intervention areas to support the delivery of FP services;
5. There will be timely and continuous availability of funding to support work plan implementation.

5. Performance Monitoring and Evaluation

This Performance Monitoring Plan (PMP) outlines the criteria that will be used to assess the outputs and outcomes of AgirPF Project in five francophone countries of West Africa between July 5, 2013 and July 4, 2018.

The use of data in programmatic decision making is an integral component of AgirPF Project. A strong monitoring and evaluation system facilitates the achievement of targets and objectives, tracks the planned use of resources, provides quantitative and qualitative data to assess outcomes, and provides all stakeholders with information on progress and results. This comprehensive PMP will help to ensure that the program is conducted in a systematic and efficient manner and provides essential feedback to ensure that the program is dynamic and responsive to changing conditions. As a new project, AgirPF will benefit from convincing documentation of the effective and appropriate implementation of program activities, as well as from evidence of the effect of those activities. The project will use a range of indicators to document program activities and, when possible, to demonstrate the outcomes of those activities.

5.1 Indicators

Indicators are signs or markers that measure one aspect of a program and show how close a program is to its desired path and outcomes. They are used to provide benchmarks for demonstrating the achievements of a program. The AgirPF Project will use a range of indicators to document and monitor implementation of project activities and, when possible, to demonstrate the outcomes of those activities. A number of these indicators feed into standard USAID West Africa Regional Health Office Performance Data Tracking indicators, as shown in Annex A which includes a detailed description of each indicator. The table in Annex A includes process and outcome indicators and annual targets for the life of the project for the five focused countries as well as definitions and the source of data for each indicator.

The list of indicators included in the indicator matrix table represents recommendations of AgirPF project staff as well as staff from the two core partners, Futures Institute and EXP Agency Ltd. These indicators were drafted during the September orientation workshop by those working in these specific areas. AgirPF reviewed the Regional Health Office indicators, PEPFAR indicators, and indicators of similar projects when deciding which indicators to select. The project took into consideration the relevance of each indicator as well as the feasibility of measuring it given the available budget. Indicator targets were set based on the country specific contexts, recent results of similar projects in the region, and the project's technical approaches. Targets, especially for years 2-5, may be adjusted based on results of the baseline assessment.

5.2 Data collection tools review and training

Given that AgirPF's approach to monitoring will prioritize data from existing sources, such as service statistics and existing data collection tools, AgirPF will coordinate with

partners to conduct a participatory review of processes, flow, and reporting systems for FP data in the Health Management Information System (HMIS) of each country, and develop/adapt monitoring tools and databases. The M&E/R Advisor will lead a participatory review in each country of HMIS processes, flow, and reporting forms, and of NGO/private-sector reporting, to ensure the project uses quality data. In addition, after this review/adaptation has been done, there will be trainings for data collectors on how to use the tools. These review processes will be organized in collaboration with the host country MOH, and with the assistance of the Country Managers and the Regional M&E/R Officer.

The training for data collectors will also be organized by both the MOH and AgirPF staff who participated to the review process. This training will includes an overview of the data collection system, data collection techniques, tools, ethics, culturally appropriate interpersonal communication skills and practical experience in collecting data. These activities will be completed in the third quarter of project Year One for Burkina Faso and Togo, and in the fourth quarter for Niger and Mauritania. AgirPF will adapt USAID's DQA tools and MEASURE's Data Demand and Use Toolkit—in particular, the proven Performance of Routine Information System Management (PRISM) Framework and tools used and evaluated by MEASURE Evaluation. AgirPF will strengthen district data systems in Burkina Faso, Togo, and will also lead similar work in Mauritania, Niger, and Côte d'Ivoire.

5.3 Data collection

AgirPF will use data collected at multiple levels, including the client, activity, service environment, government, and population levels. AgirPF's approach to monitoring will prioritize data from existing sources, such as service statistics. For each indicator without a pre-existing source, the project will develop data collection forms and instructions. Regardless of level, data are commonly divided into two general categories: routine and non-routine data.

5.3.1 Routine or monitoring data source

Routine data sources provide data that are collected on a continuous basis. AgirPF's approach to monitoring will prioritize data from existing sources, such as service statistics and existing data collection tools. AgirPF will use two primary sources of monitoring data:

- Information collected from program reports (e.g., training/activity reports, clinical monitoring visits); and
- Aggregated service statistics from the national health information system (le *Système National d'Information Sanitaire,* or SNIS) at the district level.

To measure the relative performance of the intervention strategies, service statistics describing the quantity and types of FP information and services provided will be abstracted from the service statistics collected as part of the MIS. Service statistics will be collected that describe each of the main FP services being provided, i.e. new and

revisit FP clients by type of method; number of contraceptives sold by type; number of referrals for clinical methods; etc. We will calculate CYPs based on these data as our primary strategy for monitoring changes in FP use. The project will use the most up-to-date CYP conversion factors from USAID.[1]

5.3.2 Non-routine data source

Non-routine data source will serve two purposes: informing activities and assessing the outcomes of AgirPF interventions.

- ***Facility audits***
  - To determine facility readiness (personnel, procedures, infrastructure, health care supplies, contraceptives, infection prevention, medical instruments/equipment, use of information systems)
  - To provide FP services and integrated FP/MCH services
  - To evaluate the degree to which the facilities' systems, processes and physical environment are gender-equitable, and male and youth-friendly
  - To assess quality and completeness of FP service statistics using proven frameworks, tools, and approaches

- ***Semi-structured interviews*** with national and local stakeholders such as reproductive health (RH) coordinators, other RH/FP MOH staff, and NGO partners. The purpose of these interviews will be to solicit opinions on the project's scope, suggestions for approaches to adopt/adapt, and attitudes toward FP and gender norms.

- ***Formative/market research*** using EXP's proprietary 6th Sense methodology to inform SBCC messages and materials.

- ***Household surveys of men and women*** aged 15–49 in the urban/peri-urban target areas: Using random sampling, the surveys will collect baseline data in intervention and comparison zones on the reach of SBCC campaigns and knowledge, attitudes, and practices (KAP) related to FP use.

The formative/market research will be led by EXP while the facility audits, structured interviews and household survey will be led by an external consultant at baseline and replicated at mid-term (Year 3), and end-line (See section 6.1 below for more details).

5.4 Data analysis

AgirPF will coordinate data analysis and the write-up of reports. The analysis will be descriptive and mainly focused on the examination of relevant indicators in line with the indicators described in the PMP study. All data analysis will be conducted using appropriate statistical software packages for qualitative and quantitative data.

[1] http://transition.usaid.gov/our_work/global_health/pop/techareas/cyp.html

Data collection, analysis and reporting will strive for a balanced representation of any potentially vulnerable or marginalized groups. This includes attention to differences and inequalities in society related to gender, physical or intellectual ability, religion or socioeconomic status. Therefore, AgirPF will collect and analyze data so that it can be disaggregated by sex, age and any other social distinctions that inform program decision-making and implementation.

Particular attention will be given to a gender-balanced representation. A gender-sensitive approach in health care recognizes both sex and gender differences and seeks to provide equal access to services for both women and men. Therefore, data collection and analysis will focus on how differences between women and men may affect equal access to FP services.

5.5 Data Quality Assessments (DQA)

The M&E/R Advisor will lead, in each country, a participatory review of SNIS processes, flow, and reporting forms, and of NGO/private-sector reporting, to ensure the project uses quality data. AgirPF will strengthen the SNIS if needed in order to obtain quality data. The project will use SMS or other mHealth technology to address reporting challenges, such as delays in information flow (e.g., with CHWs or staff monitoring contraceptive stocks). In general, the methodology for the review will include a mix of document and record reviews, site visits, key informant interviews, and focus groups.

AgirPF staff will verify the quality of data through:

- Working with implementing partners to ensure that they establish sound data collection and maintenance procedures;
- Spot checking data submitted by implementing partners.
- Providing feedback and mentoring to IPs to improve data quality:

When assessing data quality, AgirPF will focus on five key standards: validity, reliability, precision, integrity, and timeliness. DQAs will be conducted for each implementing partner annually.

5.6 Reporting and use of data

AgirPF staff will communicate information about progress and accomplishments to EngenderHealth headquarters in New York and to USAID/RHO by means of the activity reports cited below. All reports will first be submitted to EngenderHealth/NY for review before submission to USAID/RHO.

- Quarterly progress reports submitted 45 days after the end of each quarter
- Annual reports submitted 45 days after the end of each year

The deadline of 45 days after the end of the quarter/year will allow for both the quarterly and annual reports to include complete and final financial information on all activities from the quarter/year in all five countries.

EngenderHealth works with two categories of partners: international core project partners and local partners. Although only quarterly reports are submitted to USAID, all sub-partners will report their programmatic activities monthly to EngenderHealth.

Local sub-partners' activities are directly captured into AgirPF countries monthly reports. In each country the Senior Program Officer (SPO) and the Country Manager (CM) are responsible for providing quality control and technical review of sub-partner's reports to ensure their accuracy before their inclusion into the country's monthly report. This validation is done through regular visits of activities and reported accomplishments, monitoring visits, analysis of data, meeting and questioning beneficiaries and conducting interviews of stakeholders. After validation at the country level, each country's monthly report is sent to the AgirPF Regional Office for further analysis and use by management.

International core project partners also report progress in their activities on a monthly basis, directly to AgirPF at the regional level.

The Technical Director and the M&E/R Advisor analyze reports received, look for possible discrepancies, revert to country team with questions if needed, and when satisfied with the quality of the information received, compile all the data into one AgirPF monthly report. This monthly report goes through final review and approval by the COP and is kept as an internal document.

Each quarter, these monthly reports are compiled to produce a quarterly report that is approved and validated by the COP and EngenderHealth Headquarters in New York before its submission to USAID.

AgirPF will expand the FP knowledge base in West Africa using the MEASURE Evaluation Framework for Linking Data with Action, which helps stakeholders identify information needed to make informed decisions about BPs, encourages use of information, and monitors use of data in decision-making. We will work with partners to explore innovative non-electronic channels to help providers and others learn about results critical to their knowledge. We will produce a final report, a PowerPoint presentation, and a study brief for all models tested, as well as for baseline, mid-term and end-line assessments, highlighting key findings, recommendations, and breakthroughs, and we will capture compelling stories of providers, clients, champions, leaders, and partners via testimonials. We will disseminate evaluation and study findings, as well as training and implementation materials, via the Community of Practice. To facilitate global dissemination of knowledge about BPs, we will submit abstracts and manuscripts of results and lessons learned for publication and presentation at conferences. Peer review publications of findings will also be explored.

5.7 Dissemination

Collecting data is only meaningful and worthwhile if it is subsequently used for evidence-based decision-making. To be useful, information must be based on quality data, and it also must be communicated effectively to policy makers and other interested stakeholders. Dissemination will inform the community of stakeholders about what the project has achieved and the benefits of using it.

During the first year, AgirPF will develop a detailed dissemination plan to explain how and when the project will share outcomes with stakeholders and relevant institutions. The purpose of the dissemination activity will be to share what the project is doing, to inform and educate the community of stakeholders, to get input or feedback from the community, and to promote the project outputs. The audience targeted by this dissemination activity will include the internal stakeholders who are partners in the implementation and the external stakeholders of the West Africa region. A wide range of dissemination methods may be used: newsletters, press releases, brochures, project meetings, webinars, conference presentations, posters, workshops, reports and journal articles.

Dissemination activities will be organized during the life time of the project and message will vary with the timeframe. At the start for example, the message will focus on the awareness of AgirPF and what it is doing, and at the end the focus will be on promoting achievements. Starting in Year 2 through Year 5, it is anticipated that at least 14 workshops will be organized to disseminate evaluations (baseline, mid-term and end-line) and operations research results across the five focus countries.

5.8. Data management and storage

Data management refers to the processes and systems for how the project will systematically and reliably store, manage and access M&E data. Data will be recorded and stored in standardized formats to improve the organization and storage of data. Data formats will be physical, such as written forms stored in an office filing cabinet, or electronic, such as a spreadsheet stored in a computer database and audio (recordings of interviews, etc.).

AgirPF will use a regional online database, to be informed by DHIS 2 (District Health Information System), to track and analyze SNIS FP service statistics as well as project data on trainings, events, workshops, etc.. DHIS 2 is a free software developed by the Health Information Systems Program (HISP), a global network established, managed and coordinated by the Department of Informatics at the University of Oslo. It is a tool for collection, validation, analysis, and presentation of aggregate and transactional data, tailored (but not limited) to integrated health information management activities. DHIS 2 is the preferred health management information system in 30 countries and even more organizations across four continents. It helps governments in developing countries and health organizations manage their operations more effectively, monitor processes and improve communication. DHIS 2 is currently being used at various levels in 45

countries. The MOH in Togo, as elsewhere in the West Africa region, is currently discussing the adoption of DHIS2 as the national HMIS system. Some countries, such as Burkina Faso, have already adopted DHIS2 for national use, and apart from Mauritania, all other AgirPF countries (including Côte d'Ivoire and Niger) are in the pilot/early phases of rolling out DHIS2 for national use (see: https://www.dhis2.org/deployments).

DHIS 2 is a flexible, web-based open-source information system with visualization features including GIS, charts and pivot tables.

To reduce errors during data entry and to ensure data quality, a double data entry strategy will be used and the two data bases will be compared for consistency. Discrepancies in data entry will be logged, investigated and resolved.

AgirPF will organize its information into logical, easily understood categories to increase its access and use. Data will be organized chronologically (e.g. month, quarter, year), by location, by content or focus area (e.g. different objectives of the project), and by format (e.g. project reports, donor reports, technical documents).
Data will be easily available to its intended users and secured from unauthorized use (discussed below). Permission will be granted and controlled to access data (e.g. shared computer drives, folders, intranet). For security reasons, data will be protected from non-authorized users. This can range from a lock on a filing cabinet to computer password to access data. Data storage and retrieval will also conform to any privacy clauses and regulations for auditing purposes. The M&E/R Advisor will have the lead responsibility and accountability of data management.

At all stages of the activity (field data collection, data entry, archiving) AgirPF will be responsible for storing the information securely. Once the activity is completed, the questionnaires will be presented at AgirPF, who is the owner. Only those individuals directly involved in activity management will have access to the questionnaires and electronic data.

Data will be backed-up every month and stored on the AgirPF server in Lomé and also at EngenderHealth Headquarters in New York. In addition, a copy of the backup will be secured in an External drive stored in the AgirPF Regional Office in Lomé.

6. Evaluations (baseline, mid-term, end-line)

AgirPF will conduct a baseline evaluation in Burkina Faso, Mauritania, Niger, and Togo in Year 1 and a mid-term evaluation in Year 3, as well as an end-line process evaluation toward the end of Year 5, to assess project effectiveness and changes over time to key services, enabling environment, and demand indicators. The baseline evaluation study is the first source of non-routine data. In Year 1, before the start of any intervention , and before beneficiaries and communities learn about the intervention, AgirPF will conduct a baseline evaluation study in the 9 focus cities in Burkina Faso, Mauritania, Niger and Togo. The purpose of this baseline study will be to:

- Collect baseline data for the development of baseline indicators against which progress can be measured;
- Collect baseline data in intervention and comparison zones on the knowledge, attitudes, and practices (KAP) related to FP use in the target population;
- Collect qualitative data on AgirPF scope and approaches to adopt/adapt, and on attitudes toward FP and gender norms;
- Determine Health Facilities current readiness of service delivery points to provide quality FP services and integrated FP/MH services to clients in conformity with the existing guides and guidelines;
- Determine the degree to which the facilities' systems, processes and physical environment are gender-equitable, and male and youth-friendly;
- Assess the availability of FP information and services for adolescents.

Baseline and other evaluations will be led by external consultants. The external consultant will lead an evaluation team which will include interviewers, supervisors and data entry clerks.

This baseline evaluation study will collect both qualitative and quantitative data using the following methodologies:

- ***Facility audits***
    - To determine facility readiness (personnel, procedures, infrastructure, health care supplies, contraceptives, infection prevention, medical instruments/equipment, use of information systems) to provide FP services and integrated FP/MH services
    - To evaluate the degree to which the facilities' systems, processes and physical environment are gender-equitable, and male and youth-friendly
    - To assess quality and completeness of FP service statistics using proven frameworks, tools, and approaches

- ***Semi-structured interviews*** with national and local stakeholders such as reproductive health (RH) coordinators, other RH/FP MOH staff, and NGO partners. The purpose of these interviews will be to solicit opinions on the project's scope, suggestions for approaches to adopt/adapt, and attitudes toward FP and gender norms. All members of the district management team[2] (about 8 to 10 persons) and representatives of the NGO partners will be interviewed. It is estimated that there will be 12 to 15 structured interviews per city.

- ***Household surveys of men 15-59 and women*** aged 15–49 in the urban/peri-urban target areas: Using random sampling, the surveys will collect baseline data in intervention and comparison zones on the reach of SBCC campaigns and

[2] The district management team termed "Equipe Cadre de District (ECD)" is usually composed of the following persons: le Médecin Chef de District, le Responsable de la Santé de la Reproduction, le Responsable de l'IEC pour de la Communication pour le Changement de Comportement (IEC/CCC), le Responsable du Service d'Hygiène et de la Salubrité; le Président du Comité de Gestion (COGES); le Responsable de la Pharmacie; le Responsable du Contrôle de la Maladie; et le Responsable de la Maternité.

knowledge, attitudes, and practices (KAP) related to FP use. Using the Epi Info Statcalc program for unmatched case-control study (comparison of ILL and NOT ILL) to estimate sample size to be interviewed and assuming that: (1) CPR increase from 21 percent to 31 percent; (2) Two-sided confidence interval of 95 percent and a power of 80 percent; (3) A non-response rate of 5 percent for Togo and Burkina Faso , and of 10 percent for Niger and Mauritania; and (4) That there will be 0.95 women aged 15-49 years and 0.85 men aged 15-59 years in each household. We estimated a sample size of 1968 women and 1761 men for Togo; 2100 women and 1050 men for Burkina Faso; 1300 women and 650 men for Niger; 2994 women and 1496 men for Côte d'Ivoire; and finally 700 women and 350 men for Mauritania. The same sample sizes will be used during mid-term and end-line evaluations.

During the third year of project implementation, AgirPF will conduct a performance evaluation to assess the effectiveness of the project (how it was implemented; how it is perceived and valued; whether expected results were reached) and to identify strengths and weaknesses, lessons learned, and best practices to better guide future programs. The evaluation will be quantitative and qualitative. The methodology may include a review of activities conducted, a comparison of objectives and results, interviews with AgirPF staff and partners in the Ministry of Health, and end-line data collection at the facility level. For purposes of comparison, such a data collection exercise would share the same methodology as the baseline data collection conducted at the beginning of the project.

The baseline assessments will identify the gaps in clinic functioning that need to be addressed through the clinic strengthening intervention. The mid-term and end-line evaluations will measure the functional capacity of the clinics after the clinic-strengthening interventions and at the time of data collection on the key dependent variables. Such measures are necessary to be able to control for the level of clinic functioning during data analysis.

7. Research Studies

Research and evaluation efforts will produce data to inform program decisions. Full proposals will be developed for all evaluation and research studies that will be subject to EH's in-house ethical-review process, review by the USAID Mission, and review by a local and/or U.S.-based Institutional Review Board (IRB). EH vigorously protects the rights and welfare, both physical and psychological, of study participants, and we adhere to all standards for protection of human subjects outlined in the Common Rule. EH has experience working with USAID Global Bureau's Bureau of Operating Procedures (BOP 8) for peer-reviewed research and will apply this experience in collaborative reviews of study protocols and reports with RHO and local stakeholders.

Where appropriate, we will use experimental or quasi-experimental designs for the study design in order to collect the most accurate information. The evaluations will be conducted by an external consultant.

The project will use research studies to evaluate BPs adapted by AgirPF. For each BP, AgirPF will develop an M&E plan in consultation with key stakeholders, ensuring that (a) each model has a theory of change; (b) stakeholders concerns are addressed; and (c) both BPs and evaluations are designed with scale-up in mind, with a framework and indicators to measure the extent to which interventions are successfully scaled up. Work will align with the ExpandNet framework; draw from MEASURE's current work in developing an M&E framework/indicators for scale-up; and use EH country-program evaluation tools that focus on taking innovations and programs to scale. AgirPF will document inputs, processes, and outputs, evaluating the effectiveness and efficiency of each BP/approach, using quasi-experimental designs with baseline/end-line and comparison groups/sites when feasible and reasonable.

Methodologies will be tailored to each BP. Illustrative methodologies are: Task-shifting demonstrations, CHW first-offers showcasing, and pharmacy provision of short-acting methods through city-based services; mHealth testing; witnessing and replicating Integration of FP and immunization services.

To determine which BPs to test and scale up, AgirPF will use the ExpandNet/World Health Organization (WHO) tool "Nine steps for developing a scale-up strategy."[3]When selecting innovations to pilot, the project will ask a number of questions based on the tool, including:

1. To what extent does the practice address a felt need or policy priority?
2. To what extent does the practice have relative advantages, including cost-effectiveness, over existing or alternative practices?
3. How complex is the practice?
4. What additional human or financial resources and commodities would be needed to introduce the practice?
5. How difficult would it be to maintain the core components of the innovation as expansion proceeds?
6. What changes should be made to improve and/or adapt the practice before adopting it?

When stakeholders request scale-up of successful approaches, AgirPF will develop a participatory scale-up strategy and provide M&E per the ExpandNet framework. Barriers to expansion will be identified and addressed to ensure the realization of desired impacts, quality standards for services, and increased efficiency of approach through expansion.

7.1. Special study to measure contraceptive use dynamics: contraceptive use continuation, and reasons for switching and discontinuation in AgirPF countries (PMP indicator 5)

[3] ExpandNet, World Health Organization (WHO). Nine steps for developing a scale-up strategy. Geneva (Switzerland): WHO; 2011. http://www.expandnet.net/PDFs/ExpandNet-WHO%20-%20Beginning%20with%20the%20end%20in%20mind%20-%202011.pdf

The main objective of AgirPF is to increase access to and use of FP services in urban/periurban areas in Burkina Faso, Mauritania, Niger, Togo, and beginning in Y3, Côte d'Ivoire. Contraceptive continuation is one of the indicators for measuring the effectiveness of this objective. Data for measuring or assessing contraceptive use continuation can either be collected routinely from client records and non-routinely through a special study. But there are serious limitations and biases with using a routine data collection source:

- Routine service statistics will not capture discontinuation beyond IUD and implant removals, which are incomplete as women could have their device removed at another facility;
- For ethical reasons, EngenderHealth E&R SOPs would not allow AgirPF to review client records or follow up with clients to assess discontinuation as those clients have not previously consented to have their records reviewed or to be contacted; and finally
- Using the mHealth system to assess discontinuation[4] would not provide a full picture of discontinuation as findings would apply only to those women who participate in the mHealth system and who provide information about their discontinuation; it may also be optimistic to expect women to report discontinuation via mHealth.

Given these limitations and biases, proper measurement or assessment of contraceptive use continuation and reasons for switching and discontinuation would require data collectors to follow up with women and assess whether they continue to use the method, and if so, where they are accessing services, or whether they have discontinued or switched and, if so, why. This kind of information can only be captured through a prospective cohort study.
One of the particularities of the AgirPF monitoring and evaluation plan is to use research and evaluation to produce high quality data to inform program decisions. Therefore, discussions among EngenderHealth staff and with USAID West Africa Health Office regarding the quality contraceptive use dynamics have led AgirPF to propose collecting these data through a special study. The objective of the special study will be to measure contraceptive use continuation, and determine reasons for switching and for discontinuation in project focus countries. AgirPF will plan this special study in Y2 workplan and its implementation could start in the beginning of Y2 when Centers of Excellence have been fully established and functional.

[4] AgirPF strategies for encouraging contraceptive use continuation include using clinics and CHWs to send SMS to clients' cell phones—reminding of appointments or method-resupply dates/locations, asking if new users have method-related questions, or to ask about joining other satisfied users offering testimonials or in Community Conversations

A protocol describing the methodologies and budget will be fully developed at an appropriate time. As with all special studies, AgirPF will develop a protocol and tools that will undergo rigorous ethical and technical review by EngenderHealth in-house ethical review process, review by USAID Mission, review by local host country and US based Institutional Review Board (IRB).

8. Ethical Considerations

For all Evaluations and Research studies, EngenderHealth's ethical approval process will be followed to ensure that research ethics are respected. Every measure will be taken to ensure respect for the dignity and freedom of each individual invited to participate in the studies. During training of the data collection teams, AgirPF will place special emphasis on the importance of obtaining informed and voluntary consent of all participants, respect for confidentiality, and the prohibition of any form of coercion. Each questionnaire will be preceded by an informed consent form guiding the interviewer to present the purpose of data collection, the risks and benefits of participation, and their right to decline participation or to decline to answer any or all questions. Before each interview, the interviewer will sign the form confirming that informed consent has been obtained. To protect participant anonymity, interviewers will write no identifying information on the data collection forms.

All studies will undergo ethical review by the EngenderHealth Senior Director of Knowledge Management, who will determine if review by local and/or U.S.-based Institutional Review Board is required. The project will also obtain ethical review and approval at the country level before initiating data collection.

9. Roles and Responsibilities of Project Staff in PMP Implementation

Major sources of data and information for project monitoring and evaluation include secondary data, project output data, evaluation and OR studies. The people responsible and accountable for the data collection and analysis include community volunteers, field staff, project managers, local partners, and external consultants.

Proper management of these M&E/R data requires the involvement of all AgirPF project staff at different steps of the data collection and analysis process at different levels.
At the country level, the coordination of the data collection with data collectors is done in collaboration with the Country Manager and the Senior Program Officer involved in the implementation of technical activities. The Regional M&E/R Officer works at the country level to provide technical assistance and supervision and to ensure that quality of data are collected in the field. All data collected receive quality control. After the procedures for checking and cleaning data are implemented, data computerization and analysis is

done at the country level. This information is collected from each country and centralized at the regional level.

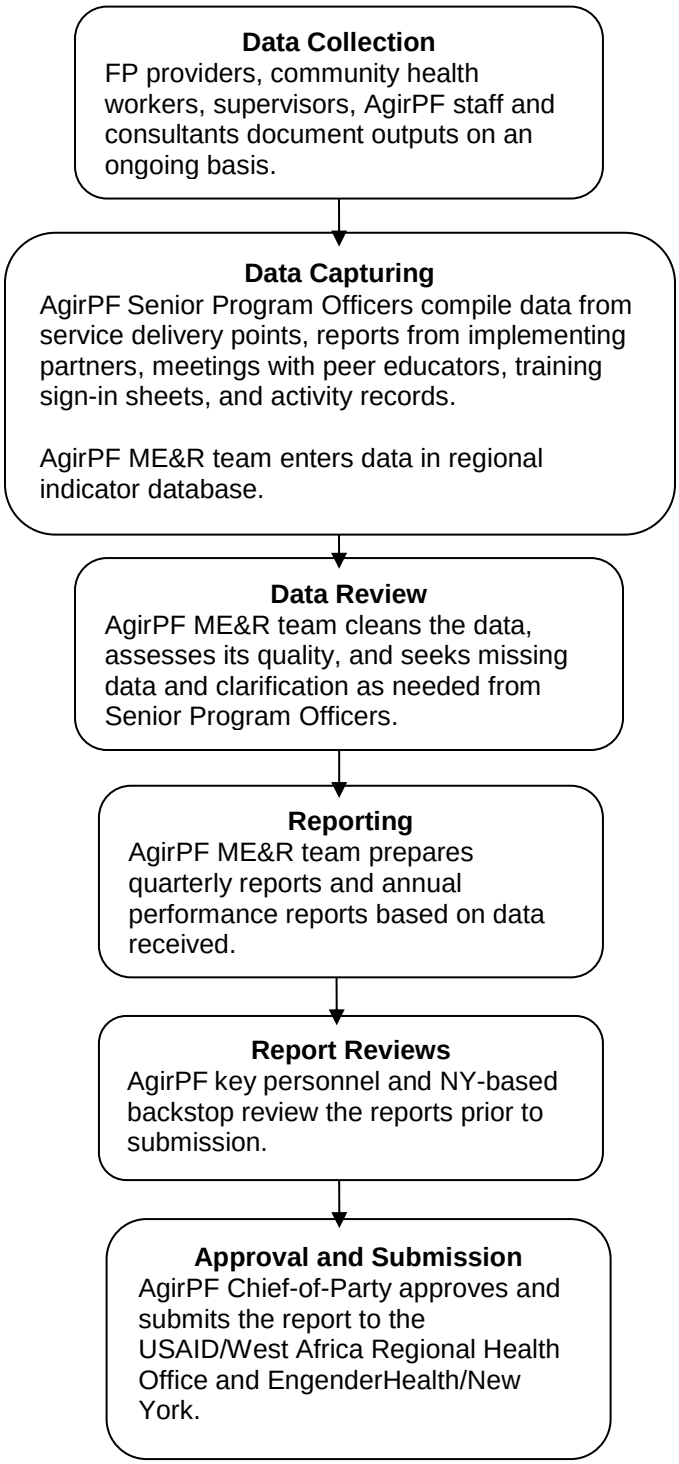
At the regional level, AgirPF key staff including Technical Director, Policy and Advocacy Advisor and the M&E/R Advisor work in team to analyze this information collected from different countries to produce relevant reports for the COP. These reports are then reviewed and approved by the COP and EH Program Managers based in New York before they are sent to USAID. Figure 2 below outlines the flow of data. At step one (Data Collection) the validation is done by the country Senior Program Officer and the Country Manager; at step two (Data Capturing) it is done by the Regional M&E/R Officer; at step three (Data Review) the validation is done by M&E/R Advisor; at step four (Reporting) the M&E/R Advisor and the Technical Director validate the report; and finally at step five (Report Review) the COP and EngenderHealth New York based backstop approve the final version of the quarterly report before it is submitted to USAID.

10. Monitoring Activities to Increase Access to FP for Disabled People[5]

It is commonly recognized that disabled people occupy in general marginal position in the society. In particular, FP services are usually inaccessible to most disabled men and women both because of the lack of physical access to service delivery points and lack of information access to FP services. AgirPF will develop an approach to have access to disabled people through the associations of disabled people. The project will work with these structures to identify ways to meet disabled FP needs.

[5] Persons with disabilities are those who are living with a physical or mental impairment such as: amputations (upper and/or lower), congenital deformities, epilepsy, paraplegia, psychiatric disorder, hearing and visual impairments.

Figure 2: AgirPF Data Flow Chart



Annex A: AgirPF PMP key indicators table

Indicator Number	Indicator Description and Type	Indicator Definition (including how measured, disaggregation) [NOTE: All indicators will include disaggregation by country and city. Additional categories of disaggregation are included in each definition.]	Source of information / Data collection method and frequency	Person(s) Responsible	Target							Notes and assumptions
					Country	Year 1	Year 2	Year 3	Year 4	Year 5	Total LOP	
SO: Increase access to and use of quality FP services in select urban and peri-urban areas of five francophone West African countries												
1.	Number of CYP achieved in AgirPF supported areas (outcome indicator)	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method (Wishik and Chen, 1973; Stover, Bertrand, and Shelton, 2000). The CYPs for each method are then summed over all methods to obtain a total CYP figure. Disaggregated by method	SNIS data in focus areas; collected Quarterly	M&E/R Advisor	Togo	712.223	395294	282353	282353	200000	1160000	
					Burkina Faso	791.471	395294	282353	282353	200000	1160000	
					Niger	456.87	205714	257143	257143	200000	920000	
					Mauritania	0	102858	128871	128871	100000	460000	
					Côte d'Ivoire	N/A	180000	240000	240000	240000	900000	
					Total	1960.564	1279160	1190420	1190420	940000	4600000	
2.	Percent of Women of Reproductive Age reported using family planning services (output indicator) USAID indicator	Proportion of Women of Reproductive Age reported using family planning services [DEFINITION TO BE FINALIZED WITH USAID/WA] Numerator = number of WRA using project services Denominator=number of WRA in defined catchment area Disaggregate by type of service (e.g. counseling, method uptake)	Project data; client registers; attendance records Quarterly	M&E/R Advisor	Togo	TBD	TBD	TBD	TBD	TBD	TBD	
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	N/A	N/A	N/A	N/A	N/A	N/A	
3.	Contraceptive Prevalence Rate (CPR) (outcome indicator)	The proportion of women of reproductive age (WRA, age 15-49) who are using (or whose partner is using) a contraceptive method at a given point in time Numerator: number of WRA who self-report using FP Denominator: number of WRA surveyed	Household Surveys Y1, Y3 & Y5	M&E/R Advisor	Togo	13	15	17	19	21	23	
					Burkina Faso	15	17	19	21	23	25	
					Niger	12	14	16	18	20	22	
					Mauritania	8	10	12	14	16	18	
					Côte d'Ivoire	15	17	19	21	23	23	
					Total	N/A	N/A	N/A	N/A	N/A	N/A	

4.	Total number of FP method users (output indicator)	The number of persons during a defined reference period (e.g., one year) who use a contraceptive method. These include all users accessing project supported sites/services for re-supply and/or method changes. Disaggregated by method, service delivery point (e.g. facility, community, mobile), age, target group (e.g. youth, post-partum, first-time parents, PAC)	Service statistics; client registers Quarterly	M&E/R Advisor	Togo		103308	142669	155582	141416	542975	Targets will be determined based on data from baseline studies in Year 1. Targets will be for all methods combined NOT specific methods.
					Burkina Faso		260563	368749	394805	358000	1382117	
					Niger		112973	171821	184559	172245	641697	
					Mauritania		86271	127529	140216	131370	485386	
					Côte d'Ivoire		244908	326544	326544	163272	1061269	
					Total		808023	1137312	1201807	966303	4113444	
5	Number of Acceptors New to Modern Contraception (output indicator) USAID indicator	The number of persons who for the first time in their lives use any (program) contraceptive method during a one year period [This indicator is a sub-set of indicator 4.] Disaggregated by method, service delivery point (e.g. facility, community, mobile), age, target group (e.g. youth, post-partum, first-time parents, PAC)	Service statistics; client registers Quarterly	M&E/R Advisor	Togo	0	47718	65899	71863	65320	250800	
					Burkina Faso	0	120354	170325	182361	165360	638400	
					Niger	0	52182	79364	85294	79560	296400	
					Mauritania	0	39849	58906	64766	60680	224200	
					Côte d'Ivoire	N/A	113123	150831	150831	75415	490200	
					Total		373226	525325	555115	446335	1900000	
6	Total number of FP continuing users (output indicator)	The number of users who initiate contraceptive use at a given point (or during a given period of time) and the length of time that each individual continues to use the method (or a substitute method). Based on this information, one can calculate the percentage who have continuously used for a specific duration (e.g., 12 months, 18 months, etc.). Disaggregated by method	Special study of CoE clients	M&E/R Advisor	Togo	TBD	TBD	TBD	TBD	TBD	TBD	This indicator will be reported for pilot studies of best practices.
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	TBD	TBD	TBD	TBD	TBD	TBD	
Result 1: Delivery of quality FP information, products, and services strengthened and expanded												
7.	Percent of FP service providers deemed technically competent based on an assessment according to national international or other defined standards (outcome indicator)	Health providers (doctors, nurses, midwives, and community health workers) will be supervised performing the FP services and counseling they were trained by AgirPF to perform. They will be assessed based on international standards for competency. "Performing up to standards" will be defined as receiving a score of at least 80%. Numerator= number of project-trained FP service providers deemed technically competent based on an assessment according to national international or other defined standards Denominator= Total number of FP service providers trained by the project Disaggregated by sex, type of provider	Facility audits, Annually	AgirPF Technical Director	Togo	80	80	80	80	80	80	
					Burkina Faso	80	80	80	80	80	80	
					Niger	80	80	80	80	80	80	
					Mauritania	80	80	80	80	80	80	
					Côte d'Ivoire	N/A	90	90	90	90	90	
					Total	80	80	80	80	80	80	

Sub Results 1.1: Partners strengthened to implement evidence-based approaches and deliver quality FP services												
8.	Number of health centers receiving "quick wins" services (output indicator)	Health centers that received equipment to offer FP services and/or organized special FP days with support from AgirPF. Disaggregated by type of assistance received, health center	Activity reports Quarterly	Country Managers	Togo	3	10	10	10	10	43	
					Burkina Faso	3	10	10	10	10	43	
					Niger	2	5	5	5	5	22	
					Mauritania	1	5	5	5	5	21	
					Côte d'Ivoire	N/A	5	5	5	5	15	
					Total	9	30	35	35	35	144	
9.	Number of local organizations with improved organizational and management capacity as measured by a defined organizational assessment tool Output indicator USAID indicator	The number of AgirPF local partners implementing AgirPF activities which are improving organizational and managerial capacity. This improvement will be measured by using the OCAT tool.	Routine supervision reports Annually	Country Managers	Togo	1	3	3	0	0	7	In Y3 PMP, we will determine the figures for Cote d'Ivoire Applies to WAAF grantees indicators
					Burkina Faso	1	5	4	0	0	10	
					Niger		4	3	1	0	8	
					Mauritania	-	3	2	0	0	5	
					Cote d'Ivoire	N/A	5	4	3	0	12	
					Total	2	20	16	4	0-	42	
10.	Number of local organizations following defined guidelines for a monitoring and evaluation plan Output indicator USAID indicator	Number count of indigenous organizations (local NGOs) that provide monthly, quarterly and annual reports on project activities using AgirPF monitoring and evaluation tools. Disaggregated by type of organization (e.g. WAAF and non-WAAF Organizations)	Routine supervision and monthly reports, Quarterly	Country Managers	Togo	1	8	9	10	10	10	In Y3 PMP, we will determine the figures for Cote d'Ivoire Applies to WAAF grantees indicators
					Burkina Faso	0	10	11	12	12	12	
					Niger	0	6	7	8	8	8	
					Mauritania	0	6	7	7	7	7	
					Cote d'Ivoire	N/A	6	7	7	7	7	
					Total	2	36	41	44	44	44	
11.	Number of FP curricula updated to include gender sensitivity, couple counseling, youth and male friendly services (output indicator)	FP curriculum integrating gender sensitivity, couple counseling, youth and male friendly services utilized Disaggregated by type of curriculum	Activity reports Quarterly	Country Managers	Togo	1	0	0	0	0	1	
					Burkina Faso	1	0	0	0	0	1	
					Niger	1	0	0	0	0	1	
					Mauritania	1	0	0	0	0	1	
					Côte d'Ivoire	N/A	N/A	1	0	0	1	
					Total	4	0	1	0	0	5	
12.	Custom Number of local non-government organizations trained and providing quality family planning and reproductive health services (outcome indicator) USAID indicator	Number of indigenous organizations (regional institutions, local NGOs) trained with USG- assistance and providing services in family planning and reproductive health.	Activity reports Quarterly	Country Manager	Togo	5	7	7	7	7	7	
					Burkina Faso	6	8	10	10	10	10	
					Niger	4	6	8	8	8	8	
					Mauritania	4	5	5	5	5	5	
					Côte d'Ivoire	N/A	5	9	12	12	12	
					Total						42	

13.	Number of people trained in family planning and reproductive health with USG funds (output indicator) USAID indicator	Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in FP/RH (including training in service delivery, communication, policy and systems, research, etc.). Disaggregated by sex male, female, type of training Type of training include: New integrated FP Curriculum, Infection prevention, Reality Check, COPE, "3Is" Approach, Updated LMIS tools, advocacy	Activity reports Quarterly	Country Manager	Togo	135	339	339	339	0	1152	This figure reflects all type of trainings (clinical, Leadership, management, Advocacy, et.)
					Burkina Faso	99	399	399	399	0	1296	
					Niger	160	235	235	235	0	864	
					Mauritania	20	154	154	154	0	480	
					Côte d'Ivoire	15	659	659	659	659	1992	
					Total	429	1786	1786	1786	0	5784	
14.	Custom Number of local organizations that meet USG financial reporting standards (output indicator) USAID indicator	Number count of indigenous organizations (regional institutions, local NGOs, health centers) that meet USG financial reporting standards according to a financial management assessment tool or checklist	Activity reports Annually	Country Manager	Togo	5	5	5	5	5		
					Burkina Faso	6	6	6	6	6		
					Niger	4	4	4	4	4		
					Mauritania	4	4	4	4	4		
					Côte d'Ivoire	N/A	N/A	3	3	3		
					Total	19	19	22	22	22		
15.	Number of HIV positive women who received comprehensive FP services[6] (output indicator)	This indicator informs about level of integration of FP services into HIV services. Meaning the providers in these specific services, have received capacity re-enforcement and are able of providing comprehensive FP services (sensitization, counselling and acceptation of a given method of contraception)	Activity reports, daily consultation registers Quarterly	Country Managers	Togo	TBD	TBD	TBD	TBD	TBD	TBD	Applies to WAAF grantees indicators
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	TBD	TBD	TBD	TBD	TBD	TBD	
16.	Number of HIV positive pregnant women who received sensitization on FP services during Ante Natal Care (ANC) (output indicator)	This indicator informs about level of integration of FP services into Mother and Child care services and particularly ANC services which practice PMTCT. During these services, HIV positive pregnant women will be receiving information about FP and will be proposed PPFP.	Activity reports, daily consultation registers Quarterly	Country Managers	Togo	TBD	TBD	TBD	TBD	TBD	TBD	Applies to WAAF grantees indicators
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	TBD	TBD	TBD	TBD	TBD	TBD	
17.	Number of HIV positive women who received Post Abortion FP (PAPF) services after an abortion (output indicator)	This indicator informs about level of integration of FP services into HIV. After an abortion HIV positive pregnant women will receive post abortion FP services. During these services, HIV positive pregnant women who aborted will be receiving information about FP and will be proposed PPFP.	Activity reports, daily consultation registers Quarterly	Country Managers	Togo	TBD	TBD	TBD	TBD	TBD	TBD	Applies to WAAF grantees indicators
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	TBD	TBD	TBD	TBD	TBD	TBD	
18.	Percent of HIV positive women sensitized in FP during ANC who effectively received Post-	Numerator: Number of HIV positive women sensitized in FP during ANC who effectively received Post-Partum FP Denominator: Number of HIV positive women sensitized in FP	Activity reports, daily consultation registers	Country Managers	Togo	TBD	TBD	TBD	TBD	TBD	TBD	Applies to WAAF grantees indicators
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	

[6] Comprehensive FP services are services which include sensitization, counselling and acceptation of a given method of contraception

	Partum FP (PPPF) services (output indicator)	during ANC	Quarterly		Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	N/A	N/A	N/A	N/A	N/A		
19.	Number of Centers of Excellence reinforced (output indicator)	Centers of Excellence reinforced means: identified, equipped, personnel trained, and performing to standard.	Activity reports Annually	Country Managers	Togo	1	1	1	1	1	1	
					Burkina Faso	1	1	1	1	1	1	
					Niger	1	1	1	1	1	1	
					Mauritania	1	1	1	1	1	1	
					Côte d'Ivoire	N/A	N/A	1	1	1	1	
					Total	4	4	5	5	5	5	
20.	Number of special FP days conducted (output indicator)	Special FP days are days where the range of FP services are offered free of charge or at low cost by dedicated providers. Typically, this strategy expands the reach of a range of FP services: trained providers travel to remote facilities to expand the range of methods offered.	Activity reports, daily consultation registers Quarterly	Country Managers	Togo	10	10	10	10	10	50	
					Burkina Faso	10	10	10	10	10	50	
					Niger	10	10	10	10	10	50	
					Mauritania	10	10	10	10	10	50	
					Côte d'Ivoire	N/A	N/A	10	10	10	30	
					Total	40	40	50	50	50	230	
21.	Number of industry based health fairs conducted (output indicator)	Industry health facilities identified, and Industry based health fairs conducted Disaggregated by type of industry	Activity reports, daily consultation registers Quarterly	Country Managers	Togo	8	8	8	8	8	40	
					Burkina Faso	4	4	4	4	4	20	
					Niger	4	4	4	4	4	20	
					Mauritania	4	4	4	4	4	20	
					Côte d'Ivoire	N/A	N/A	8	12	12	32	
					Total	20	20	28	32	32	132	
22.	Number of CHWs supported and supervised (output indicator)	CHWs supported (trained, equipped with kits) and supervised Disaggregated by age, sex, type of training (FP, HIV/AIDS, MCH)	Activity reports Quarterly	Country Managers	Togo	0	216	180	1800*	180*	216	*Starting in Year 3, City Based Services (CBS) will be introduced. CBS implementers called City Based Health Workers (CBHW) will be introduced in Year 3 and will be transferred to MOH in Year 5
					Burkina Faso	-	-	1600	160*	1680*	160	
					Niger	-	-	180	180*	180*	180	
					Mauritania	-	-	75	75*	75*	75	
					Côte d'Ivoire	N/A	-	240	240*	2400*	240	
					Total	0	216	835	835	835	835	

23.	Number of community-based services that have been transferred to local/national health authorities (output indicator)	Community-based services will be transferred to country authorities in starting in year 3 where these services were piloted. Disaggregated by type of service	Activity reports Annually	Country Managers	Togo	0	0	156	N/A	N/A	2	
					Burkina Faso	-	-	-	-	TBD	-	
					Niger	-	-	-	-	TBD	-	
					Mauritania	-	-	-	-	TBD	-	
					Côte d'Ivoire	N/A	N/A	-	-	TBD	-	
					Total	0	0	156	N/A	TBD	2	
Sub Result 1.2: Local leaders, civil society, service providers, municipal government support and promote FP												
24.	Number of experiential message development workshops held (output indicator)	AgirPF partner EXP Agency Ltd. will use its "6th Sense Methodology" to gain insights into community members' views of FP through experiential workshops. Disaggregated by type of participant/community member	EXP partner report Quarterly	EXP	Togo	1	0	0	0	0	1	
					Burkina Faso	1	0	0	0	0	1	
					Niger	0	1	0	0	0	1	
					Mauritania	0	1	0	0	0	1	
					Côte d'Ivoire	N/A	N/A	1	0	0	1	
					Total	2	2	1	0	0	5	
25.	Number of men and women reached with FP messages through interpersonal communication (output indicator)	Using insights from message development workshops, AgirPF will utilize a variety of SBCC approaches, such as leading community conversations about FP and holding industry-based health fairs. Disaggregated by SBCC approach, age, sex	Activity reports Quarterly	EXP	Togo	50000	50000	50000	50000	0	200000	AgirPF will only count participants who appear to be age 15 or older toward this indicator.
					Burkina Faso	50000	50000	50000	50000	0	200000	
					Niger	0	50000	50000	50000	0	150000	
					Mauritania	0	50000	50000	50000	0	150000	
					Côte d'Ivoire	N/A	N/A	50000	50000	50000	150000	
					Total	100000	200000	250000	250000	50000	850000	
26.	Proportion of women and men reporting increased dialogue with their partner about FP (outcome indicator)	A man or a woman is reporting dialoguing with their partners if during the last three month they discussed at least once regarding FP issues including the choice and/or use of a given FP method Numerator: Number of women and men reporting dialogue with their partner about FP Denominator: Total number of women and men interviewed Disaggregated by age	Pre and post-Household KAPB surveys Y1 baseline, Y3 mid-term, Y5 end-line	M&E/R Advisor	Togo	TBD	TBD	TBD	TBD	TBD	TBD	According to Household survey results, this Indicator will be defined Targets
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	N/A	N/A	N/A	N/A	N/A	N/A	
27.	Changes in community/religious leaders' attitudes toward FP (outcome indicator)	Community and/or religious leader attitudes will be assessed to determine positive changes in terms of their belief in the benefits of FP for women and men, and their involvement in FP promotion efforts at the community level. Community and/or religious leaders' understanding and knowledge of FP will be assessed to determine improvements in their ability to: describe at least two benefits of FP for women and men; list the various FP methods. Disaggregated by sex.	Pre and post=KAPB surveys or FGDs Project activity reports. Y1 baseline, Y3 mid-term, Y5 end-line	M&E/R Advisor	Togo	TBD	TBD	TBD	TBD	TBD	TBD	According to Household survey results, this Indicator will be defined Targets
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	N/A	N/A	N/A	N/A	N/A	N/A	

28.	Proportion of target population with gender-equitable attitudes (outcome indicator) Modified USAID indicator	Attitudes of women and men will be assessed to determine improvements in terms of: their support for women's sexual and reproductive rights; their support for women's right to practice a contraceptive method; their support for men's involvement in the promotion of women's sexual and reproductive health; their support for joint decision-making about FP; their support for consensual sex in a relationship; their support for women's involvement in decision-making at the household level; their support for men's involvement in child care; their resistance to all forms of violence against women; their support for women's human rights. Disaggregated by age and sex	Household KAPB survey Y1 baseline, Y3 mid-term, Y5 end-line	M&E/R Advisor	Togo	TBD	TBD	TBD	TBD	TBD	TBD	Base d on the Baseline study, a Target will be associated, year after year, to this indicator
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	NA	N/A	TBD	TBD	TBD	TBD	
					Total	N/A	N/A	N/A	N/A	N/A	N/A	
29.	Changes in provider attitudes on gender issues (outcome indicator)	Provider attitudes will be assessed to determine improvements in terms of: their support for women's sexual and reproductive rights; their support for women's right to practice a contraceptive method; their support for women's right to seek reproductive health information and services; their support for men's involvement in the promotion of women's sexual and reproductive health; the promotion of joint decision-making about FP; their promotion of consensual sex; their support for men's involvement in child care; their resistance to all forms of violence against women; their support for women's human rights. Improvements in provider attitudes will also be assessed based on providers' self-reports of times when they: communicated the importance of joint decision-making about FP during their consultations with clients; communicated the importance of consensual sex during their consultations with clients; and communicated the importance of men's in involvement in women's sexual and reproductive health during their consultations with clients. Disaggregated by sex.	Provider interviews, Supervision guides Y1 baseline, Y3 mid-term, Y5 end-line	M&E/R Advisor	Togo	TBD	TBD	TBD	TBD	TBD	TBD	According to Household survey results, this Indicator will be defined Targets
					Burkina Faso	TBD	TBD	TBD	TBD	TBD	TBD	
					Niger	TBD	TBD	TBD	TBD	TBD	TBD	
					Mauritania	TBD	TBD	TBD	TBD	TBD	TBD	
					Côte d'Ivoire	N/A	N/A	TBD	TBD	TBD	TBD	
					Total	N/A	N/A	N/A	N/A	N/A	N/A	
30.	Number of the targeted population reached with individual and or small group level HIV prevention interventions that are based on evidence and or meet standards required (PEPFAR output-#P8.1D) (output indicator) USAID indicator	Number of individuals in the general population reached with individual/small group level HIV prevention interventions (See PEPFAR Next Generation Indicator Guide for full definition).	Activity reports Quarterly	Senior Program Officer and Country Manager	Togo	-	28750	29540	30253	31188	119831	
					Burkina Faso		34500	35449	36424	37425	143798	Applies to WAAF grantees indicators
					Niger		14950	15361	15784	16218	62312	
					Mauritania		13800	14180	14569	14970	67519	
					Côte d'Ivoire		57500	59081	60706	62375	239663	
					Total		149500	153611	157736	162176	623023	

31.	Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (PEPFAR Output #P8.3.D) (output indicator) USAID indicator	Number of individuals in most -at-risk-populations reached with individual/ small group level HIV prevention interventions (See PEPFAR Next Generation Indicator Guide for full definition). Disaggregation by MARP type: MSM, CSW, Other Vulnerable Populations	Activity reports Quarterly	Senior Program Officer and Country Manager	Togo		5175	5175	5175	5175	20700	Applies to WAAF grantees indicators Only for WAAF grantees working specifically with MARPs
					Burkina Faso		6210	6210	6210	6210	24840	
					Niger		2691	2691	2691	2691	10764	
					Mauritania		2484	2484	2484	2484	9936	
					Côte d'Ivoire	N/A	10350	10350	10350	10350	41400	
					Total		26910	26910	26910	26910	107640	
32.	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results. (PEPFAR Output#P11.1D) (output indicator) USAID indicator	Number of individuals who are, at a minimum, providing services of counseling, testing, return and receipt of test results (See PEPFAR Next Generation Indicator Guide for full definition). Disaggregated by Gender-24a. men, 24b.women	Activity reports Quarterly	Senior Program Officer and Country Manager	Togo		17250	17724	18212	18713	71899	Applies to WAAF grantees indicators
					Burkina Faso		20700	21269	21854	22455	86278	
					Niger		8970	9217	9470	9731	37387	
					Mauritania		8280	8508	8742	8982	34512	
					Côte d'Ivoire	N/A	34500	35449	36424	37425	143798	
					Total		89700	92167	94702	97306	373874	
33.	Number of youth who participate in educational program on gender, FP, and SRH (output indicator)	AgirPF will adapt EngenderHealth's teen pregnancy prevention curriculum for use with youth in West Africa. This will be led by peer educators who would lead discussions as moderators with enhanced knowledge on FP. Disaggregated by sex	Sign-in sheets, activity reports city Quarterly	EXP	Togo	0	15000	15000	15000	0	45000	
					Burkina Faso	0	15000	15000	15000	0	45000	
					Niger	0	15000	15000	15000	0	45000	
					Mauritania	0	15000	15000	15000	0	45000	
					Côte d'Ivoire	N/A	N/A	15000	15000	20000	50, 000	
					Total	0	0	60,000	75,000	20000	230,000	
34.	Number of health facility walk-throughs conducted (output indicator)	Local community leaders (e.g., women's group leaders, traditional leaders, youth leaders) will visit the health centers serving their community. Providers will show them the path of a FP client through the facility. Community leaders and providers will then identify barriers to access at the community and facility levels and develop and implement action plans to address those barriers. Disaggregated by type of leader, facility	Sign-in sheets, activity reports city Quarterly	Technical Director	Togo	3	6	6	6	6	27	
					Burkina Faso	3	6	6	6	6	27	
					Niger	2	4	4	4	4	18	
					Mauritania	1	3	3	3	3	13	
					Côte d'Ivoire	N/A	N/A	2	3	3	8	
					Total	9	19	21	22	22	93	

Result R2: Evidence-based service delivery approaches selected, adapted, and implemented

35.	Number of BPs for family planning and maternal and child health and/or HIV/AIDS incorporated into local, district or national health protocols or standards (outcome indicator)	Evidence of BPs for family planning and maternal and child health and/or HIV/AIDS incorporated into local, district or national health protocols or standards Milestone Indicator: Each time a milestone is met, we have achieved a result. Step 1: BP accepted by MOH Step 2: BP replicated by MOH Step 3: BP scaled-up Step 4: BP integrated into national guidelines Disaggregate by FP, HIV/AIDS, MCH, level (local, district, national), protocol, standard	District or National health protocols or standards Quarterly	Country Manager	Togo	-	2	1	0		3	
					Burkina Faso	-	2	1	0		3	
					Niger	-	2	1	0		3	
					Mauritania	-	1	1	0	-	2	
					Côte d'Ivoire	N/A	2	1			3	
					Total	-					3	
36.	Percent coverage of children under five years of age reached with health services (malaria, pneumonia, and diarrhea). (output indicator) USAID indicator	Proportion of children under five in the community who have been cared by the Community-IMCI for Malaria, Pneumonia and Diarrhea episodes Denominator: Number of under five years old children in intervention zone Numerator: Number of children under five years of age reached with health services (malaria, pneumonia, and diarrhea) Disaggregated by sex, type of illness	CHW activity reports Quarterly	Country Manager	Togo	10	12.5	15	17.5	20	N/A	Numbers are very low because we are working in cities. N/A for total : percent average not very useful
					Burkina Faso	10	12.5	15	17.5	20	N/A	
					Niger	10	12.5	15	17.5	20	N/A	
					Mauritania	10	12.5	15	17.5	20	N/A	
					Côte d'Ivoire	N/A	N/A	15	17.5	20	N/A	
					Total	10	12.5	15	17.5	20	N/A	
Sub-result 2.1: Efficiency and effectiveness enhanced through adaptation and implementation												
37.	Number of new family planning approaches successfully introduced through USG supported programs (output indicator) USAID indicator	Number of new approaches (e.g., tools, technologies, operational procedures, information systems, etc.) successfully introduced into recipient or country programs Disaggregated by type of approach	Reports Quarterly	M&E/R Advisor	Togo			2			4	
					Burkina Faso			2			4	
					Niger			2			4	
					Mauritania			1			4	
					Côte d'Ivoire	N/A		2			4	
					Total							
38.	Number of best practices piloted through operations research studies (output indicator)	Operations research (OR) studies have been conducted by the project. "Operations research" studies refer to applied studies examining the causes of and possible solutions to observed program operational problems (Blumenfeld, 1985; Fisher et al., 1991).	OR reports, other research Annually	M&E/R Advisor	Togo	1	-	-	1	-	2	
					Burkina Faso	1	-	-	1		2	
					Niger	-	1	-	-	-	1	
					Mauritania	-	1	-	-	-	1	
					Côte d'Ivoire	N/A	N/A	-	1	-	1	
					Total	2	2	-	3	-	7	

		Data Requirements: Evidence, in the form of reports or other outputs of OR studies and/or evidence of staff involvement in ongoing studies that operations research studies have been conducted										
Sub-results 2.2: Lessons documented and disseminated from adaptation and implementation												
39.	Number and type of lessons from adaptation and implementation that have been documented and disseminated (output indicator)	Research and evaluation results are regularly disseminated to key external audiences (e.g., key government agencies, the news media, the research community, etc.). "Dissemination" refers to the formal communication of program–related research and evaluation findings through such channels as research briefs, publications, workshops, conferences, news releases, etc. Data requirements: Evidence of events or instances in which research and evaluation findings have been disseminated. Disaggregation by types of research (evaluation, OR studies), and by channels of dissemination (reports, research briefs, publications, workshops, conferences, news releases, abstract accepted, articles or letters published, websites, etc.)	Research and dissemination reports Annually	M&E/R Advisor	Togo	0	0	1	1	0	2	
					Burkina Faso	0	0	1	1	0	2	
					Niger	0	0	1	1	0	2	
					Mauritania	0	0	1	1	0	2	
					Côte d'Ivoire	N/A	0	0	1	1	2	
					Total	0	4	*5*	1	*0*	10	
40.	Custom Number of regional technical meetings organized and supported by the Regional Health Office and its partners (output indicator) USAID indicator	Number count of technical meetings, conference calls, initiated by RHO/RHO partners with other donors, civil society organizations with a regional focus. A meeting is counted as regional if representatives from at least 50% of the targeted 14 NPCs or 21 countries covered in WA attend	Reports Annually	M&E/R Advisor	Togo	1	1	2	1	1	6	
					Burkina Faso	0	2	1	1	0	5	
					Niger	0	0	1	1	0	2	
					Mauritania	0	0	0	1	0	1	
					Côte d'Ivoire	N/A	1	1	1	1	4	
					Total	1	4	5	5	1	18	
41.	Custom Number of publications, presentations and meetings to disseminate program data to key stakeholders (output indicator) USAID indicator	Number count of occasions that program data is shared with key stakeholders (USAID/WA FO, USAID/W, USAID/AFR, host country government institutions, US Embassies, clients, civil society institutions, US public) Disaggregated by electronic, official meeting, conference	Reports Quarterly	M&E/R Advisor	Togo	0	3	3	3	4	15	
					Burkina Faso	0	3	3	3	4	15	
					Niger	0	3	3	3	4	15	
					Mauritania	0	3	3	3	4	15	
					Côte d'Ivoire	N/A	1	2	3	4	9	
					Total	8	12	14	15	20	69	

Result R3: Efforts to remove policy barriers and improve contraceptive commodity security coordinated

Sub-results 3.1: Policy barriers identified and new/revised policies adopted and implemented

42.	Number of policies, national health standards and guidelines developed or changed, including scale-up (outcome indicator)	Number of policies, national health standards and guidelines developed or changed, including scale-up Disaggregated by type of policy	Key informant interviews, policies and guidelines Quarterly	Policy and Advocacy Advisor	Togo	1	0	1	0	0	2	
					Burkina Faso	0	1	0	1	0	2	
					Niger	0	0	1	0	1	2	
					Mauritania	0	1	0	1	0	2	
					Côte d'Ivoire	N/A	N/A	0	0	1	1	
					Total	1	2	2	2	2	2	
43.	Number of policies or guidelines developed or changed with USG assistance to improve access to and use of family planning and reproductive health services (output indicator) USAID indicator	Number of new policies, laws and guidelines introduced as a result of USG-assistance related to improvement in Family Planning and reproductive Health Services	Key informant interviews, policies and guidelines Annually	Policy and Advocacy Advisor	Togo	0	0	2	1	0	3	Column total is not necessary as the same policies and guidelines may be developed or changed in different countries.
					Burkina Faso	0	0	2	1	0	3	
					Niger	0	0	2	1	0	3	
					Mauritania	0	0	2	1	0	3	
					Côte d'Ivoire	N/A	0	2	1	0	3	
					Total						3	
44.	Number of advocacy strategies developed by organization (output indicator)	AgirPF will develop an advocacy strategy which includes a comprehensive listing and details of relevent policy barriers that need to be addressed as part of SR 3. AGIRPF will refer to the Health Policy Project's recent analyses of policy barriers in developing these strategies. In addition, the project will provide technical assistance to local organizations to develop their own advocacy strategies. Disaggregated by organization	Reports Quarterly	Policy and Advocacy Advisor	Togo	1	0	0	0	0	1	
					Burkina Faso	1	0	0	0	0	1	
					Niger	1	0	0	0	0	1	
					Mauritania	1	0	0	0	0	1	
					Côte d'Ivoire	N/A	N/A	1	0	0	1	
					Total	4	0	1	0	0	5	
45.	Number of advocacy presentations created or updated (in collaboration with FI and HPP) (output indicator)	AgirPF will support countries to develop or update country-specific advocacy presentations, including RAPID models Disaggregated by theme of presentation	Reports Quarterly	Policy and Advocacy Advisor	Togo	1	N/A	N/A	N/A	N/A	1	For Burkina Faso and Togo, the activity will be an update of RAPID models that were done in 2011. For Mauritania and Niger, this will be the first RAPID model done in those countries.
					Burkina Faso	0	1	N/A	N/A	N/A	1	
					Niger	0	1	N/A	N/A	N/A	1	
					Mauritania	1	N/A	N/A	N/A	N/A	1	
					Côte d'Ivoire	N/A	N/A	1	N/A	N/A	1	
					Total	2	2	1	N/A	N/A	5	

46.	Custom Number of new Maternal and Child Health policies implemented after 6 months according to defined standards (output indicator) ***USAID indicator***	Number of new policies, guidelines and laws implemented after 6 months of introduction, as a result of USG-assistance, related to improvement of Maternal and Child Health	Signed document approving new policies and/or guidelines and/or laws by health authorities Annually	Policy and Advocacy Advisor	Togo	-	1	-	1	-	2	Applies to WAAF grantees indicators
					Burkina Faso	-	1	-	1	-	2	
					Niger	-	1	-	1	-	2	
					Mauritania	-	-	1	1	-	2	
					Côte d'Ivoire	N/A	-	1	1	-	2	
					Total	-	3	2	5	-	10	
47.	Number of advocacy activities conducted (output indicator)	AgirPF will support the initial launch of advocacy activities for the RAPID presentation to policy makers at the country-level. Disaggregated by topic, level (district, regional, national), national policymaker, religious leader, local government official, community leaders, type of activity	Reports Quarterly	Policy and Advocacy Advisor	Togo	3	1	1	1	1	7	
					Burkina Faso	0	3	1	1	1	6	
					Niger	0	3	1	1	1	6	
					Mauritania	3	1	1	1	1	7	
					Côte d'Ivoire	N/A	N/A	3	1	1	5	
					Total	6	8	7	5	5	31	
Sub-results 3.2: Contraceptive commodity needs identified and coordinated among partners and country commodity security and logistics management												
48.	Number of Contraceptive Procurement Table (CPT) team members and partners trained to use Reality ✓ (output indicator)	Reality ✓ is an EngenderHealth tool for FP forecasting, planning, and advocacy. Contraceptive Procurement Teams and partners will be trained to use the tool. This indicator refers to the number of individuals trained. Disaggregated by age, sex, profession/type of team member	Sign-in sheets, activity reports Quarterly	Policy and Advocacy Advisor	Togo	15	0	0	0	0	15	
					Burkina Faso	15	0	0	0	0	15	
					Niger	15	0	0	0	0	15	
					Mauritania	0	15	0	0	0	15	
					Côte d'Ivoire	N/A	N/A	15	0	0	15	
					Total	45	15	15	0	0	75	
49.	Number of COPE exercises for Contraceptive Security held (output indicator)	COPE exercises for Contraceptive Security will be conducted at facility level. Disaggregated by facility	Activity reports, action plans Quarterly	Technical Director	Togo	3	6	6	0	0	15	
					Burkina Faso	3	6	6	0	0	15	
					Niger	2	4	4	0	0	10	
					Mauritania	1	3	3	0	0	7	
					Côte d'Ivoire	N/A	N/A	2	3	0	5	
					Total	9	19	21	3	0	52	
50.	Number of SDP reporting stock-outs of contraceptives per quarter (outcome indicator)	SDP reporting stock-outs of contraceptives per quarter. Disaggregated by district, method, duration (days)	Health facility stock reports, inventories reports Quarterly	Country Managers	Togo	4	5	4	7	5		Total LOP not necessary because is meaningless. Number of SDPs increase over time but stock out rate is presumed to decrease by 5% per year : 30% in Y1 to 10% in Y5
					Burkina Faso	4	5	4	8	6		
					Niger	3	4	3	6	4		
					Mauritania	2	2	2	3	2		
					Côte d'Ivoire	N/A	N/A	4	3	4		
					Total	13	16	17	27	21	94	